Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HARRIS METHODIST FORT WORTH
3255 WEST PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-06-0863-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to information we have received from TWCC regarding a medical billing database for services in 2004, trauma claims received and average payment that was 48.2% of charges. Because this information was acquired from TWCC from a Medical Dispute filed, we are considering this to be a 'fair and reasonable' calculation for trauma reimbursement."

Amount in Dispute: $9,198.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester failed to prove its billing of usual and customary is fair and reasonable." "The requester has not shown that the fees paid to date fall below the statutory standard. It is the carrier's position that a party seeking recovery of medical fees from a workers' compensation carrier under the Texas Workers' Compensation Act has the burden of proof to establish by a preponderance of the credible evidence that the fees sought are allowable under the Act. It is equally applicable in this case, where the requester has already received payment from the Carrier for the very same services for which it now seeks additional payment, the requester has the burden of establishing by a preponderance of the credible evidence that the Carrier's payment fall short of the fee payments required by §413.011, Tex. Labor Code, and that an additional, specified amount of money must be paid to reach the payment level established by §413.011."

Response Submitted by: Linda Estrada, Texas Mutual Insurance Co., 6210 East Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 2004 through October 29, 2004	Inpatient Services	$9,198.47	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on September 26, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 Texas Register 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on October 6, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F-Fee guideline MAR reduction.
   - M-No MAR.
   - 426-Reimbursed to fair and reasonable.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.
   - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - CAC-143-Portion of payment deferred.
   - 420-Supplemental payment.
   - 891-The insurance company is reducing or denying payment after reconsideration.
   - CAC-18-Duplicate claim/service.
   - 878-Duplicate appeal. Request medical dispute resolution through DWC for continued disagreement of original appeal decision.
   - Reimbursement made per carrier determine fair and reasonable for in-patient sty for trauma code.

Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 813.42. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "According to information we have received from TWCC regarding a medical billing database for services in 2004, trauma claims received and average payment that was 48.2% of charges. Because this information was acquired from TWCC from a Medical Dispute filed, we are considering this to be a 'fair and reasonable' calculation for trauma reimbursement."
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - The requestor did not provide documentation of information from TWCC regarding a medical billing database for services in 2004, supporting that trauma claims received an average payment that was 48.2% of charges.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the

Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 TexReg 6276 (July 4, 1997). It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 TexReg 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/7/2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.